SECTION A: 20 MARKS

QUESTION 1: Multiple Choice

1.1 Hygiene in hospital care is categorized as:

Correct: A. Personal and environmental hygiene.

Incorrect: B. Medical and surgical hygiene.

Incorrect: C. Preventative and curative hygiene.

Incorrect: D. Personal and preventative hygiene.

1.2 The nurse analyses and examines choices more independently and starts questioning the decision made is:

Incorrect: A. Basic level.

Correct: B. Complex level.

Incorrect: C. Commitment level.

Incorrect: D. Interpretation level.

1.3 The nursing process is best defined as:

Incorrect: A. A routine task performed by nurses during patient care.

Correct: B. A systematic method of planning, delivering, and evaluating individualized care for clients in any state of health or illness.

Incorrect: C. A medical approach used only for treating diseases.

Incorrect: D. A set of hospital rules guiding nursing practice.

1.4 The step of nursing process that involves collecting patient data is called:

Incorrect: A. Diagnosis.

Incorrect: B. Planning.

Correct: C. Assessment.

Incorrect: D. Evaluation.

1.5 Hypotension refers to:

Incorrect: A. Increased blood pressure.

Correct: B. Decreased blood pressure.

Incorrect: C. Normal blood pressure.

Incorrect: D. Elevated pulse rate.

QUESTION 2: Definitions

2.1 Hygiene: Practices conducive to maintaining health and preventing disease.

2.2 Recording: Documenting patient care, observations, and treatments in medical records.

2.3 Assessment: Systematic collection, organization, and validation of patient data.

2.4 Dyspnea: Difficult or labored breathing.

2.5 Hypothermia: Abnormally low body temperature.

2.6 Hyperventilation: Rapid or deep breathing leading to excessive carbon dioxide exhalation.

2.7 Cyanosis: Bluish skin discoloration due to inadequate blood oxygenation.

2.8 Tachypnoea: Abnormally rapid breathing.

2.9 Fever spike: A sudden, rapid increase in body temperature.

2.10 Objective data: Measurable and observable information, such as vital signs.

QUESTION 3: Fill in the Blanks

3.1 An **actual problem** is a problem that already exists when the nurse interacts with the patient.

3.2 The technique that uses **postural drainage** to assist with the drainage of secretions from various lung regions into larger bronchi.

3.3 The procedure for removing secretions by **suctioning**.

3.4 Acute cough comes suddenly and lasts for two to three weeks.

3.5 Nursing diagnosis focuses on identifying responses to health and illness that can change from day to day.

SECTION B: 30 MARKS

QUESTION 1

1.1 Nursing interventions for dry skin:

- ✓ Maintain adequate hydration.
- ✓ Apply emollients or moisturizers to cracked/dry areas.

1.2 Factors predisposing to pressure sores:

- ✓ Immobility,
- ✓ friction,
- ✓ shear,
- ✓ moisture,
- ✓ poor nutrition, and
- ✓ sensory impairment.

1.3 Steps of problem-solving:

- ✓ Define the problem.
- ✓ Analyze the problem.
- ✓ Generate possible solutions.
- ✓ Select the best solution.
- ✓ Implement the solution.
- ✓ Evaluate the outcome.

QUESTION 2

2.1 Factors affecting sleep cycle:

- ✓ Stress,
- ✓ environmental changes,
- ✓ lifestyle changes
- ✓ diet, and
- ✓ illness.

2.2 Purpose of record keeping:

- ✓ Continuity of care.
- ✓ Legal documentation.
- ✓ Communication between the healthcare team.

2.3 Consequences of poor record keeping:

- ✓ Legal risks.
- ✓ Compromised patient safety.
- ✓ Fragmented of care
- ✓ ineffective care.

2.4 Critical thinking for patient safety:

- ✓ Improves clinical judgment to prevent errors.
- ✓ Allows for proactive identification of patient risks.

QUESTION 3

3.1 When to measure vital signs:

- ✓ Upon admission.
- ✓ According to facility policy.
- ✓ Before/after surgery or procedures,
- ✓ when a patient's condition changes.

3.2 Components of the nursing process:

- ✓ Assessment,
- ✓ Diagnosis,
- ✓ Planning,
- ✓ Implementation, and
- ✓ Evaluation.

3.3 Intervention for cyanosis:

- ✓ Assess airway and breathing.
- ✓ Administer oxygen as prescribed
- ✓ Look for assistance to notify the physician immediately.